2006

State Disabilities Plan

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Section 1

The Maryland Department of Disabilities (MDOD) presents the 2006 State Disabilities Plan and pledges to work collaboratively with all units of State government to refine steps necessary to bring services to people with disabilities that are meaningful, accessible, and consistent with the principles of consumer empowerment.

- Executive Summary

EXECUTIVE SUMMARY

The Maryland Department of Disabilities (MDOD) presents the 2006 State Disabilities Plan as mandated in § 9-1117. This plan, the second since the inception of the Department, builds upon the process of collaboration articulated in the 2005 State Disabilities Plan. MDOD remains committed to working with State departments administering programs for individuals with disabilities for the purpose of bringing services to people that are meaningful, accessible, and consistent with the principles of consumer empowerment.

The mission of this Department is to empower people with disabilities to achieve their personal and professional goals in communities where they live. The State Disabilities Plan frames this mission and addresses the vision, goals and suggested strategies for each of the service domains specified in statute or other mandates. The nine service domains include: Community Integration, Housing, Transportation, Employment and Training, Health and Behavioral Health, Technology and Communities, Education, Family Support Services, and Emergency Preparedness.

Maryland spends a substantial amount of its budget for services to people with disabilities through 98 discrete primary disability programs (in excess of $3.7 billion, exclusive of nursing homes and other programs to the elderly population). The State Disabilities Plan is a statewide effort to consolidate vision and policy under the auspices of the Maryland Department of Disabilities employing several key strategies to improve and reform disability services. These include mapping the resources already being expended in each service area, focusing on common critical success factors across service areas, and garnering extensive and ongoing stakeholder input.

The Department's *Five Areas of Focus* remains the standardized measure by which MDOD assesses the State Disabilities Plan. The focus areas include: Accountability, Service Integration and Operational Improvements, Capacity Development, Community Integration, and Alignment of State Policies and Practices with Principles of Empowerment.

Additionally, the State Plan Score Sheet serves as a tool for planning, tracking and measuring critical success factors. These include projected fiscal impact, strategies to streamline operations, efforts to promote systems integration, and assurances that accountability standards will be met.

Ongoing input from people with disabilities, advocates and service providers is emphasized. MDOD has and continues to meet with representative organizations statewide to identify those issues that are deemed most critical to the disability community. It is from these meetings that the outcomes and key strategies are derived, refined, and in some cases, replaced.

This State Disabilities Plan is the roadmap that MDOD uses to unify expectations for positive outcomes for people with disabilities. When people with disabilities are given the right training and opportunities, they can succeed in all aspects of life. The dream of economic self-sufficiency, community integration, educational attainment and independent living are possible for people with disabilities—if we do our part.

Section 2

Carrying out the Maryland Department of Disabilities' (MDOD) charge to improve and reform disability services requires an interagency and disciplined approach. This section provides an overview of the component strategies of this approach including key statutory mandates and methods to implement them. Specifically, this section addresses the following items:

- The Statewide Disability Implementation Plan – Overview
- Process for Developing the State Disabilities Plan
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THE STATEWIDE DISABILITY IMPLEMENTATION PLAN – OVERVIEW

Maryland currently spends in excess of $3.7 billion per year on services to people with disabilities through 98 different agencies representing almost 16 percent of the total State budget. Programs are housed in a variety of departments and at varied levels of government. As a result, the system often falls short of meeting the needs of the end user because it is fragmented and duplicative.

The State Disabilities Plan is an interagency plan that enables Maryland to, through a deliberate process, design and assess a comprehensive system rather than isolated components—a process established through legislation and intended to unify service delivery, eliminate fragmentation and ensure accountability across State government.

The State Disabilities Plan assesses and provides strategies to improve self-directed, long-term and attendant care; housing; transportation; employment and training; education; somatic and mental health; accessible and universally-designed technology; and support services for families. In addition, the plan strives to assure that Maryland is in compliance with relevant federal and state provisions intended to protect the civil rights of individuals with disabilities, such as the US Supreme Court's *Olmstead* decision.

PROCESS FOR DEVELOPING THE STATE PLAN

Resource Mapping:

Attaining meaningful improvements within the system requires a phased-in multi-year plan targeted at achieving clear outcomes. A critical step in this planning effort is resource mapping. Resource mapping is a comprehensive method of assessing the current delivery system through strategic data collection and analysis and is the foundation for planning, program consolidation and performance-based management of services.

Five Areas of Focus:

MDOD's state planning efforts and recommendations revolve around five principle areas of focus. They include: Accountability, Service Integration and Operational Improvements, Capacity Development, Community Integration, and Alignment of Policies and Funding with Principles of Empowerment. The following information describes these five focus areas and provides a succinct rationale for each.

Accountability

Accountability is fundamental to quality, programmatic improvements, and the effective use of limited resources within the disability service delivery system. It informs decision-makers, demands change, reshapes organizational cultures, challenges misperceptions, and democratizes policy development. MDOD is committed to holding itself and all government and service providers accountable for outcomes as well as to promoting consumer responsibility.

State planning efforts focus on a variety of accountability strategies. They include: creating interagency and common outcomes; developing meaningful performance indicators; establishing knowledge management systems; assessing consumer satisfaction; promoting public access to government and provider performance data; providing incentives for improved performance; and collecting benchmark data. These and other accountability standards will generate the transparency and knowledge needed to create and sustain peak performance.

Service Integration and Operational Improvements

Service delivery programs and funding decisions developed in isolation from one another frequently result in different and even contradictory outcomes, values and processes. This disjointed approach creates fragmentation, duplication and confusion for the end-user. Eliminating this chaotic approach within the existing disability delivery system is a priority for MDOD and the disability community alike.

Achieving this goal requires a thoughtful examination of the structure and operations of disability services followed by a planned and rational approach for change. Specifically, the State Disabilities Plan recommends strategies to consolidate administrative redundancies, reduce needless process burden, synthesize appropriate personnel

functions, and restructure workflow. In addition, the Maryland Department of Disabilities will recommend program consolidation and the relocation of programs when appropriate.

Alignment of State Policies and Practices with Principles of Empowerment

The principles and values upon which policies are predicated fundamentally impact programmatic and consumer outcomes. A service delivery system that is not driven by clearly understood and articulated principles based on consumer empowerment will inevitably (and often unconsciously) adopt practices that are contradictory, undermine successful consumer outcomes and foster mediocrity. In contrast, deliberately aligning policies and practices with expressed values such as consumer choice and self-determination creates programs that are both empowering and successful.

The State Disabilities Plan strives to align the broad spectrum of disability services with principles of empowerment. Expanded consumer choice; self-directed and individualized planning; integration; community-based services; consumer responsibility; elevated expectations; and equal access are just some of the values behind MDOD's planning efforts and recommendations. Consistently applying these values to State practices and policies will promote a cohesive and unified approach to service delivery.

Capacity Development

Developing the service delivery system's capacity to meet the real needs of people with disabilities is key to implementing systemic change. Inadequate capacity inevitably impedes an individual from accessing the variety of services needed to live an independent and productive life. In addition, limited capacity can drain minimal resources and put an undue strain on other services—often resulting in cost shifting. For example, lack of affordable housing forces many individuals to continue residing in nursing homes rather than their communities. Sporadic and sometimes poor coordination of transportation funding consumes limited resources that otherwise could be used more effectively for employment, independent living and other important services.

The State Disabilities Plan focuses on improved system capacity by adopting goals to identify: gaps in service delivery, numbers of individuals needing services, projected costs for additional services, and other quantifiable factors. Benchmarking lays the foundation for creating realistic solutions that consider interagency resources and needs. This State Disabilities Plan (as will future plans) recommends strategies to improve specific capacity needs across all of the service domains.

Community Integration

In 1999, the US Supreme Court issued the *Olmstead v. L.C.* decision. The *Olmstead* decision interpreted Title II of the Americans with Disabilities Act by requiring that states administer services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." In its decision, the Supreme Court noted that unnecessary institutionalization of individuals with disabilities is discriminatory. This interpretation, combined with accompanying federal changes to policies and funding, reflects society's growing awareness that individuals with disabilities can thrive and live meaningful lives in their communities rather than in nursing homes or institutions.

The Governor Robert L. Ehrlich, Jr. Administration is committed to fully complying with the *Olmstead* decision. To this end, MDOD collaborates with other state agencies to develop innovative and fiscally-viable strategies by which individuals with disabilities can access services in their communities. This requires identifying those in need of community-based services; aligning the funding of services with community-based alternatives; expanding the quality and quantity of community providers; educating consumers about their community options; reviewing policies, regulations and practices to ensure that they support community; and collaborating with all stakeholders to create appropriate and integrated alternatives for people with disabilities. The State's efforts to comply with the *Olmstead* decision will allow individuals with disabilities to contribute to their communities in ways that enrich the lives of all Maryland citizens.

State Plan Score Sheet – A Balanced Approach:

Recommendations included in the State plan are filtered through the State Plan Score Sheet (see Appendix 1). The State Plan Score Sheet is used to prompt planning efforts, to track progress, and to ensure that recommendations address a variety of critical success factors that more specifically break down the five focus areas. Such factors include a recommendation's projected fiscal impact, strategies to streamline operations, efforts to promote systems integration and assurances that accountability standards will be met. Success factors are categorized into three areas: consumer perspectives, organizational performance and processes and structures.

Stakeholder Input:

The State Disabilities Plan is intended to be a fluid document with the propensity to adapt as new variables and needs are highlighted. The State Disabilities Plan reflects the varied input from people with disabilities and their families, advocates, providers and government representatives. MDOD staff continuously meets with disability stakeholders statewide to pinpoint community needs, system breakdowns and successes.

The Interagency Disabilities Board:

The Interagency Disabilities Board is comprised of Cabinet Secretaries or their designees and chaired by the Secretary of MDOD. It is charged with continuously developing recommendations; evaluating funding and services for individuals with disabilities; identifying performance measures; and working with the Secretary of the Department of Disabilities to create a seamless, effective and coordinated delivery system.

This body will be responsible for both plan development and implementation—being held accountable for results that improve outcomes for the end-user.

Maryland Commission on Disabilities:

The Maryland Commission on Disabilities was established in statute to provide guidance to MDOD in the development of the State Disabilities Plan. Sixteen individuals with disabilities or representative

of stakeholder groups are appointed by the Governor and sit with two members of the Interagency Disabilities Board and two legislators to create a vibrant body intended to move disability issues to the forefront of government. Commission members chair, co-chair or play other significant roles in the work of subcommittees created by the Commission. Because the Commission is primarily composed of individuals with disabilities, the Department has ongoing feedback and input from those most impacted by recommendations and outcomes of the State Disabilities Plan.

RESPONSIBILITIES OF UNITS OF STATE GOVERNMENT IN THE STATE PLANNING PROCESS

Defining a Unit of State Government:

MDOD's enabling statute defines a unit of state government as: any department, agency, office, commission, council, or other unit of the State within the Executive Branch of state government (§ 9-1101).

Because this definition is broad, MDOD has the authority to wave certain requirements pertaining to the responsibilities of units of government, including their obligation to develop and submit unit plans. For purposes of this State Disabilities Plan, units of state government will be defined as principal departments within the Executive Branch of state government and administrations within these principal departments. Appendix 2 delineates principal departments and administrations that will participate in the unit plan progress assessment by April 1, 2006, and an evaluation of their performance by July 1, 2006. (Section 4 contains a more detailed timeline for unit plan progression and assessment and submission dates)

Unit Plans:

Units of state government play a key role in implementing the goals and outcomes of the Statewide Disability Implementation Plan. Specifically, units of government shall:

- Develop and submit to MDOD by July 1 annually a unit plan that includes an implementation schedule and measurable objectives for any services provided to people with disabilities. The unit plans shall be consistent with the goals and outcomes outlined in the State Disabilities Plan (§ 9-1108).

- Provide an evaluation of the prior year's plan by July 1 of each year that assesses their attainment of their unit plan objectives. Evaluation criteria should include levels of consumer satisfaction, gaps in services, wait list numbers and progress made on their plan (§ 9-1108).

Section 4 of this document outlines the specific information MDOD requires from units of state government as well as suggested strategies for developing cohesive and integrated action plans. MDOD and units of state government work closely together with various stakeholders to create optimal outcomes for people with disabilities and their families.

ADDITIONAL RESPONSIBILITIES OF UNITS OF STATE GOVERNMENT AND MDOD

Responsibilities:

In addition to developing and assessing action plans, units of state government will interface with the Department of Disabilities on a variety of fronts.

- Units of state government are required to provide information to the Secretary of MDOD regarding current programs and services for individuals with disabilities and information regarding new or proposed programs (§ 9-1107). The Secretary shall then review new or proposed changes to regulations, policies, programs and services submitted by a unit of state government that relate to the provision of resources and services to individuals with disabilities prior to public notification (§ 9-1104).

- The Secretary shall review, coordinate and concur with applications for federal aid, waivers, or grants submitted by or through any units of State government when the applications are specific to disability services (§ 9-1104).

These requirements establish a coordinated and disciplined review process designed to ensure that services are delivered in a manner consistent with the stated goals and objectives of the State Disabilities Plan, as well as in a manner that avoids unanticipated duplication or fragmentation. Units of state government will identify a point person to work with MDOD as a conduit of information between the two entities regarding these requirements. Ongoing interactions between MDOD policy staff and units of state government support a fluid exchange of information.

The Regulatory Review Process and Impact Statement:

The enabling statute (§ 9-1104) requires units of state government to provide proposed changes to regulations to MDOD for comment prior to publication. Additionally, agencies must provide an impact statement if the proposed change affects individuals with disabilities. Appendix 3 details this process.

Section 3

This section contains the specific outcomes, strategies, and proposed action steps that are the underpinnings of MDOD's State Plan. Driven by consumer input, performance measurement, concrete deliverables and timelines, this comprehensive plan will result in meaningful improvements for the disability community.

Each service domain includes vision and goal, followed by measurable outcomes and strategic recommendations.

The 2006 State Plan infuses the principles of the Olmstead Decision throughout all of the domains thus eliminating the need for a separate domain dealing with this area. This is also consistent with the incorporation of Community Integration into the 2006 Plan.

Outcomes and strategic recommendations are organized by service domains. The domains include:

- Community Integration
- Housing
- Transportation
- Employment
- Health and Behavioral Health
- Technology and Communities
- Education
- Family Support Services
- Emergency Preparedness

COMMUNITY INTEGRATION

Vision: People with disabilities will have access to a wide range of options in choosing their own community supports as alternatives to institutional care settings.

Goal: Maryland citizens with disabilities will be served in the most integrated setting appropriate to their needs.

Outcome 1: People with disabilities will be transitioned or diverted from institutions at a reasonable pace.

Key Strategy 1.1
Assess individuals to determine their individual preferences and needs for living in the community.

Action Steps:

1.1.1 By July 1, 2006, and by July 1 each year thereafter submit a plan to effectively promote, facilitate, and support community integration statewide for individuals in the most integrated setting appropriate to their needs. Scope of plan shall include existing programs and services that have an assessment of long-term care service needs for people with disabilities as a primary function or component. (See plan checklist in Appendix 4.)
Quarterly reports will be submitted to MDOD beginning July 1, 2006, which includes action status, outcomes, and challenges.
Responsible Unit(s): DHMH Office of Health Services (Medicaid), DDA.
Beginning July 1, 2007: FHA, MHA, MDOA, and DHR

1.1.2 Office of Health Services (Medicaid) will continue implementation and track results as required by Health General Article 15-135 to assess individuals in nursing facilities who express a preference for community placement. Data will be reported to MDOD quarterly.
Responsible Unit(s): Office of Health Services (Medicaid)

1.1.3 MHA will complete its inclusive stakeholder process to determine how to screen consumers who reside for extended periods in state psychiatric facilities. Findings will be reported to MDOD by July 1, 2006.
Responsible Unit(s): MHA

1.1.4 DDA will complete person-centered planning, with an independent resource coordinator, for all consumers residing at State Residential Centers and report results to MDOD by July 1, 2006.
Responsible Unit(s): DDA

1.1.5 By December 1, 2006, assess the effectiveness and quality of state assessment methods and tools used to determine individual preferences and needs for living in the community (e.g. AERS STEPS, Options Counseling, DDA Resource Coordination, MHA Stakeholder Screening process, Hospital Outreach Project, DHR Social Services to Adults, MDOA Senior Care and MD Access Point)
Responsible Unit(s): MDOD and Maryland Commission on Disabilities

Key Strategy: 1.2
Successfully transition individuals residing in state funded facilities (SRCs, psychiatric hospitals, RICAs, chronic hospitals and nursing facilities) to the community who have expressed a desire to do so.

Action Steps:
1.2.1 By July 1, 2006, and by July 1 each year thereafter submit a plan to effectively promote, facilitate, and support community integration statewide by gathering and analyzing information, planning service delivery, and reporting outcomes. Quarterly report to be submitted to MDOD which includes action status, outcomes, and challenges. (See plan checklist in Appendix 4.)
Responsible Unit(s) 2006: DDA, Office of Health Services (Medicaid)
Responsible Unit(s) 2007: DDA, Office of Health Services (Medicaid), FHA, MHA

1.2.2 Annually, collect data for the MDOD Managing for Results (MFR) indicators showing (a) the proportion of individuals with disabilities served in state funded institutional settings (i.e. nursing facilities, state hospitals and state residential centers) versus community settings and (b) the percentage of individuals wishing to live in the community that are discharged from state facilities into services in the community, and other related performance indicators.
Responsible Unit(s): Lead: MDOD; Participants: DBM, DHMH (Office of Health Services (Medicaid), DDA, MHA)

Key Strategy: 1.3
Successfully divert individuals from placement in state funded facilities who have expressed a desire to remain in their community.

Action Steps:

1.3.1 By July 1, 2006, and by July 1each year thereafter submit a plan for effectively promoting, facilitating, and supporting community integration statewide by gathering and analyzing information, planning service delivery, and reporting outcomes.(See plan checklist in Appendix 4.)

Quarterly report to be submitted to MDOD which includes action status, outcomes, and challenges.
Responsible Unit(s) 2006: DDA, Office of Health Services (Medicaid), DHR, and MDOA
Responsible Unit(s) 2007: DHMH (DDA, Office of Health Services (Medicaid), FHA, MHA), DHR, and MDOA

1.3.2 Expand State efforts to divert people from unnecessary nursing facility placements into community settings with appropriate supports.
Responsible Unit(s): Office of Health Services (Medicaid); Participants: MDOD

Outcome 2: People with disabilities will be provided community support services in the most integrated community setting based on their needs and preferences.

Key Strategy 2.1
Develop the capacity to provide people with disabilities the types and amounts of long term community support services necessary in the most integrated community-based setting appropriate.

Action Steps:

2.1.1 By July 1, 2006, and by July 1 each year thereafter submit a plan for effectively promoting, facilitating, and supporting community integration statewide by gathering and analyzing information, planning service delivery, and reporting outcomes. Quarterly report will be submitted to MDOD which includes action status, outcomes, and challenges. (See plan checklist in Appendix 4.)
Responsible Unit(s) beginning 2006: DHMH (Office of Health Services (Medicaid), DDA)
Beginning 2007: MHA, FHA, MDOA, and DHR.

2.1.2 By November 1, 2005, establish the Personal Assistance Advisory Committee as mandated by the legislature to provide guidance to the State on personal care, attendant care, and home care services, including the following tasks: development of training standards, recommendations on appropriate compensation for workers, and a determination on the feasibility of establishing referral and registry systems for workers and recipients of personal assistance services.
Responsible Unit(s): MDOD; Participants: DHMH, MDOA, and all other mandated members of the Advisory Board.

2.1.3 By January 1, 2006, establish the State Traumatic Brain Injury Advisory Board to advise the State on the extent of needed services by people with traumatic brain injury, identify gaps in current services, facilitate interagency collaboration, and make recommendations to build capacity and fund an adequate level of services for people with brain injuries.
Responsible Unit(s): Co-leads MDOD and MHA; Participants: All mandated members of the Advisory Board.

Outcome 3: People with disabilities will report an increase in their quality of life based on self-defined quality indicators and outcomes that reflect the highest level of expectation for increased choice, meaningful relationships, economic security, and other measures associated with quality of life.

Key Strategy 3.1
Develop, pilot, implement, and evaluate consumer driven approaches to measuring quality of life of individuals with disabilities.

Action Steps:

3.1.1 By April 2006, implement the Consumer Quality Team strategy using mental health consumers and family members developed by the Consumer Quality Team Steering Committee (See Health and Behavioral Health, action step 2.1.1 for related strategy on the creation of the Mental Health Transformation Working Group [MH-TWG])
Responsible Unit(s): Lead: MHA; Participants: MDOD; MH-TWG and Consumer Quality Team Steering Committee

3.1.2 Annually on July 1, DDA will continue to implement and disseminate the "Ask Me" quality of life survey in which self-advocates collect data from peers conducted at agencies and other program sites and share information on findings with MDOD.

Responsible Unit(s): DDA

3.1.3 By December 2005, convene a Consumer Satisfaction and Quality Outcomes Steering Committee for Long Term Care to explore and recommend uniform definitions of quality, quality indicators, outcome measures, assessment tools, program requirements, and consumer monitoring policy for all services to individuals with disabilities. The steering committee will recommend ways to create meaningful roles for consumers in peer mentoring, monitoring and assuring quality in all community programs and waivers. The steering committee will recommend ways to assure that all programs have a consumer quality monitoring "advisory" committees.
Responsible Unit(s): Lead: MDOD; Participants: DHMH (Office of Health Services (Medicaid), MHA, DDA) MDOA, DHR, consumers, advocacy groups, and community programs.

Outcome 4: People who want to self direct their services will do so.

Key Strategy 4.1
Develop, pilot, implement, and evaluate expanded opportunities for people with disabilities to self-direct their own services.

Actions Steps:

4.1.1 By September 2006, Maryland will implement the recommendations of the Task Force on Self-Directed Mental Health Care, including those concerned with broad systemic interventions and those focused on specialized pilots of self-directed care for mental health consumers. (See Health and Behavioral Health, action step 2.1.1 for related strategy on the creation of the Mental Health Transformation Working Group MH-TWG)
Responsible Unit(s): Co-leads: MHA, MDOD; Participants: MH-TWG, On Our Own of Maryland

4.1.2 As of January 2006, DDA will continue the implementation of the New Directions waiver for consumer self direction by people with developmental disabilities and report on progress of implementation to MDOD
Responsible Unit(s): DDA

4.1.3 By January 2006, convene a group to recommend a universal definition for self-directed services (i.e. consumer-directed services) and recommend outreach and education strategies for shifting state-funded

services for people with disabilities in community programs and waivers including the Community Choice waiver.

Responsible Unit(s): Lead: MDOD; Participants: Maryland Commission on Disabilities (MCOD), DHMH, MDOA, DHR, consumers, advocates, and providers.

HOUSING

Vision: People with disabilities will have a full array of housing options similar to their non-disabled peers.

Goal: To provide people with disabilities with affordable, accessible housing in their communities with linkages to appropriate support services.

Outcome 1: People with disabilities will spend no more than 30 percent of their incomes on housing.

Key Strategy 1.1
By January 1, 2006, establish a bridge subsidy program which will allow individuals to transition from institutions to their communities while awaiting other, more permanent housing supports (such as Section 8).

Action Steps:

1.1.1 By January 1, 2006, develop a plan to assess outcomes and benefits of the bridge subsidy pilot program. The assessment plan should address aggregate cost savings or expenses to implementation resulting from the pilot; consumer-driven and quality of life outcome measures; and processes which will identify challenges/barriers.
Responsible Unit(s): DHCD

1.1.2 By January 1, 2006, secure funding for the Bridge Subsidy Pilot Program for years two and three.
Responsible Unit(s): Co-leads: DHCD and MDOD

Key Strategy 1.2
Examine the feasibility of including an option in any long-term care waiver submitted to CMS proposing that housing costs of eligible participants be covered under a capitated rate system.

Action Step:
Action step for this strategy is currently being developed and will be available to the public by March 2006.

Key Strategy 1.3
(Ongoing Strategy) Work in coordination with DHCD to implement the Governor's Commission on Housing recommendations that will benefit individuals with disabilities.

Action Step:

1.3.1 Include the needs of individuals with disabilities, including individuals at SSI levels of income, in any plans developed to implement the Commission's final recommendations which are germane to this population.
Responsible Unit(s): DHCD

Outcome 2: People with disabilities will be able to locate housing in communities of their choice.

Key Strategy 2.1:
By May 1, 2006, establish and maintain an up-to-date and comprehensive housing registry which connects individuals with disabilities with available, accessible and affordable housing.

Action Step:

2.1.1 By January 1, 2006, identify funds to hire a housing coordinator. The housing coordinator will be responsible for maintaining the housing registry and to be the single point of entry to: coordinate and collaborate efforts of the State agencies serving Medicaid consumers; increase capacity for affordable and accessible housing with long-term supports; and work with local governments to provide private builders with incentive for developing accessible and affordable housing within local communities.
Responsible Unit(s): Co-leads: DHCD and MDOD

Outcome 3: People with disabilities will have the supports and services necessary to make their dwellings accessible through modifications.

Key Strategy 3.1
By July 1, 2006, develop low-cost wheelchair ramp construction projects to serve residents with low incomes in Wicomico County and Baltimore City that are sustainable in other areas of the State.

Action Steps:

3.1.1 By November 1, 2005, initiate Wicomico County project in partnership with Eastern Shore Center for Independent Living, Wicomico County Department of Corrections, Wicomico County Public Schools and two building contractors.

3.1.2 By July 1, 2006, initiate Baltimore City project jointly with the Living Classrooms Foundation and other partner agencies.
Responsible Unit(s): Lead(s): MDTAP, Eastern Shore Center for Independent Living, Living Classrooms Foundation;

Participant(s): Wicomico County Department of Corrections, Wicomico County Public Schools, et al.

Key Strategy 3.2
By May 2006, develop a Maryland Housing Modification Resource Guide to provide a complete listing of available supports to persons who need to modify their home to make it accessible.

Action Steps:
Action steps for this strategy are currently being developed and will be available to the public by March 2006.
Responsible Unit(s): MDOD/MDTAP

Outcome 4: Increase home ownership opportunities for persons with disabilities in Maryland.

Key Strategy:
Key Strategy for this outcome is currently being developed and will be available to the public by March 2006.

Action Steps:
Action steps for this strategy are currently being developed and will be available to the public by March 2006.

TRANSPORTATION

Vision: People with disabilities will use an array of transportation options to access destinations enjoyed by their non-disabled peers.

Goal: To create reliable, cost-effective transportation enabling people with disabilities to access destinations of their choosing at the same rate as their non-disabled peers.

Outcome 1: People with disabilities will have improved confidence in MDOT's para-transit system.

Key Strategy 1.1
By June 30, 2006, strengthen the implementation of the policy of "Nothing about me, without me" whereby consumers who use para-transit are routinely consulted regarding procedures and solutions to problems.

Action Steps:

1.1.1 MTA, in conjunction with CACAT, will continue the training protocol for all MTA and Mobility personnel that will be conducted by consumers who use the para-transit system.
Responsible Unit(s): Lead: MTA; Participants: CACAT, MDOD

1.1.2 MTA will continue to identify intersections of opportunity within agency planning exercises and procurement development to solicit input from the CACAT Committee.
Responsible Unit(s): Lead: MTA; Participants: CACAT; MDOT

1.1.3 MTA, in conjunction with CACAT, will enhance the public's perception of Mobility's performance and consumer-friendly posture.
Responsible Unit(s): Lead: MTA; Participants: MDOD; CACAT; MDOT

Key Strategy 1.2
By June 30, 2006, evaluate methods of enhancing the role of CACAT.

Action Step:

1.2.1 MDOD and MTA will consult with the members of CACAT, individuals with disabilities and representative organizations regarding ways in which to strengthen CACAT's effectiveness.

Responsible Unit(s): Lead: DOD; Participants: MDOT; MTA; CACAT, consumers and providers

Key Strategy 1.3
Continue to monitor MDOT's on-time goal of 95% for para-transit trips.

Action Step:
1.3.1 By December 31, 2006, MTA will develop a reporting and monitoring process among stakeholders that includes performance criteria, Federal Transit Administration trends, and consumer feedback in the provision of para-transit services.
Responsible Unit(s): Lead: MTA; Participants: CACAT, DOD; consumers and providers.

Key Strategy1.4
By December 31, 2006, expand creative options such as the Taxi Access program.

Action Steps:
1.4.1 MTA will extend the process of Taxi Access certification to include all of the certified para-transit users.
Responsible Unit(s): Lead: MTA; Participants: MDOT; CACAT, MDOD

1.4.2 MTA will expand the number of Taxi Access sub-contractors, to include providers of taxi service to the users of wheelchairs.
Responsible Unit(s): Lead: MTA; Participants: MDOT; CACAT, MDOD; consumers and providers

Outcome 2: People with disabilities will use fixed route transportation in greater numbers.

Key Strategy 2.1
On December 31, 2005, 100% of MTA buses will be fully accessible (e.g., low floored, Clever Devices) to enable a greater number of people to ride fixed routes.

Action Step:
2.1.1 MTA will assure compliance with procurement timelines to keep the acquisition of fully accessible vehicles on schedule.
Responsible Unit(s): Lead: MTA; Participants: MDOD; MDOT; CACAT, providers, consumers.

Key Strategy 2.2
By December 31, 2006, examine the feasibility of uniform standards to assess para-transit certification to be used by physicians to also include an assessment of whether or not travel training could allow an individual to ride fixed route.

Action Step:

2.2.1 By July 1, 2006, convene a group of stakeholders to review the para-transit certification standards and ultimately, recommend ways in which the standards can be modified to enhance independence on the part of users. The group should also recommend ways to increase the availability and types of travel training provided.
Responsible Unit(s): MTA, MDOD, CACAT

Key Strategy 2.3
By July 1, 2006, examine the technical feasibility, cost feasibility, and schedule feasibility of providing cross-regional transportation capacity in both the fixed route and para-transit systems to enable people with disabilities to travel across regions using different systems.

Action Step:
Action step for this strategy is currently being developed and will be available to the public by April 1, 2006.

Outcome 3: People with disabilities who rely on provider-run transportation to get to a human service program (DDA, MHA, DOA, etc.) will experience shorter trips, increased flexibility, and streamlined scheduling.

Key Strategy 3.1
Key Strategy for this outcome is currently being developed and will be available to the public by April 1, 2006.

EMPLOYMENT AND TRAINING

Vision: Marylanders with disabilities will have a variety of meaningful employment and training opportunities, the incentive to work, and choose and control the individualized services that support their diverse careers in integrated settings.

Goal: To ensure Marylanders with disabilities to receive individualized supports and quality training leading to integrated employment offering competitive wages and benefits.

Outcome 1: People with disabilities will experience an increase in meaningful employment outcomes.

Key Strategy 1.1
By October 2006, develop baseline measures and determine means of ongoing data collection to measure progress towards achievement of this outcome.

Action Steps:

1.1.1 By January 2006, a data subcommittee of the Employment Services Transformation Steering Committee will begin meeting to determine up to three cross agency measurable employment outcomes, key performance measures and review existing employment data and data collection. An interim set of recommendations will be submitted to Secretary Cox by July 1, 2006.
Responsible Unit(s): Lead: MDOD Participants: DDA, MHA, DORS, DLLR, Office of Health Services (Medicaid), non state agencies

1.1.2 By July 1, 2006, a consultant will be hired to prepare final recommendations and collect cross agency baseline data
Responsible Unit(s): Lead: MDOD Participants: DDA, MHA, DORS, DLLR, Office of Health Services (Medicaid), non state agencies

1.1.3 By September 1, 2006, a final report with recommendations and baseline data will be submitted to Secretary Cox.
Responsible Unit(s): Lead: MDOD Participants: DDA, MHA, DORS, DLLR, Office of Health Services (Medicaid), non state agencies

Key Strategy 1.2
By December 2006, enhance the abilities of employers (both private and public) to hire qualified individuals with disabilities.

Action Steps:

1.2.1 By January 1, 2006, DLLR's Lead Disability Program Navigator will have in place a timeline and action plan to coordinate existing employer outreach activities and the Business Leadership Network based on input from key stakeholders and the BLN and subject to the approval of MDOD and the State BLN Leadership.
Responsible Unit(s): Lead: DLLR Participants: MDOD, DORS, DLLR, DDA, MHA, GWIB

1.2.2 By February 2006, DBM will submit recommendations to improve the efficacy of the Special Options Eligible Program to Secretary Cox.
Responsible Unit(s): Lead: DBM

1.2.3 By July 2006, a minimum of 20 candidates will be accepted into the Quest Internship program.
Responsible Unit(s): Lead: DBM

1.2.4 By September 1, 2006, a multimedia campaign, Work Matters, will be undertaken to highlight Maryland employers and their successful employees with disabilities and to encourage other employers to hire individuals with disabilities.
Responsible Unit(s): Lead: MDOD, DBED, DLLR, GWIB Participants: DDA, MHA, DORS

1.2.5 By December 1, 2006, an Employer Summit, planned and led by the business community, will be convened by the Governor to highlight best practices and encourage the private and public sector to actively seek out and hire qualified candidates with disabilities.
Responsible Unit(s): Lead: MDOD, DBED, DLLR, GWIB Participants: DORS, DDA, MHA

1.2.6 By July 2005, DGS will implement a minimum of two recommendations of the Procurement Preferences Task Force.
Responsible Unit(s): Lead: DGS

Outcome 2: People with disabilities will have access to a broad array of employment training options that are consumer-directed in communities where they live.

Key Strategy 2.1
By October 1, 2006, increase consumer's ability to direct their employment and training services with an emphasis on accessing community-based and integrated services and employment.

Action Steps:

2.1.1 By March 2006, MDOD will have a website that offers information and resources on how to access services that lead to employment outcomes in community based and integrated settings.
Responsible Unit(s): Lead: MDOD Participants: Office of Health Services (Medicaid), DDA, MHA, DORS

2.1.2 By April 2006, MDOD will hire a Consumer Outreach Coordinator to meet with consumers in sheltered non-work and work settings to inform them of resources and supports available to assist them in achieving their employment goals in integrated settings in their communities.
Responsible Unit(s): Lead: MDOD Participants: Office of Health Services (Medicaid), DDA, MHA, DORS

2.1.3 By July 2006, MDOD will have an online database that allows individuals with disabilities to create an individualized employment related resources list based on a variety of criteria to include geographical location, and potential eligibility.
Responsible Unit(s): Lead: MDOD Participant: Office of Health Services (Medicaid)

2.1.4 By January 1, 2006, DDA, MHA and DORS will provide MDOD with a list of agency action plans/priorities (based on recommendations or reports developed i.e. Joe Marrone/John Halliday report, DDA Self Determination Employment Task Force, DORS statewide needs assessment etc) and how MDOD can assist or support implementation of those recommendations.
Responsible Unit(s): Leads: DDA, MHA, DORS

2.1.5 By April 1, 2006, reconvene the Employment Services Transformation Steering Committee to review progress towards implementation of recommendations and to update and develop additional recommendations.
Responsible Unit(s): Leads: MDOD; MD Workforce Promise Participants: DORS, DLLR, DDA, MHA, Office of Health Services (Medicaid), non-state agencies, advocates

2.1.6 By July 2006, MHA will convene a committee of stakeholders including consumers and families to review Mental Health Vocational Program regulations and develop recommendations for changes that will lead to increased employment outcomes.
Responsible Unit(s): Lead: MHA, Participants: MDOD, DORS, non state agencies, families and consumers

Key Strategy 2.2
By October 2006, expand availability and accuracy of information regarding employment training programs, expand availability of services where necessary, and public access to their performance data.

Action Steps:

2.2.1 See 1.1.1 and 2.1.2
Responsible Unit(s) Lead: MDOD Participants: Participants: DDA, MHA, DORS, DLLR, Office of Health Services (Medicaid), non-state agencies

2.2.2 By May 2006, DLLR will submit recommendations and analysis of potential costs based on meeting with DDA, MHA, DORS and MDOD regarding the potential of cross agency partnership to track labor market and wages of individuals with disabilities receiving employment services.
Responsible Unit(s) Lead: DLLR Participants: DORS, DDA, MHA, Office of Health Services (Medicaid)

Outcome 3: People with disabilities will have increased ability to independently locate, identify and pursue employment.

Key Strategy 3.1
By December 2006, all employment training programs will better prepare individuals with disabilities to independently explore careers and job opportunities.

Action Steps:

3.1.1 By March 2006, DORS, DDA, MHA and DLLR will develop a cross agency Common Intake form.
Responsible Unit(s): Lead: DORS Participants: MDOD, DDA, MHA, DLLR

3.1.2 By March 2006, DORS will implement deemed eligibility for VR services for consumers served by DDA and MHA.
Responsible Unit(s): Lead: DORS

3.1.3 By October 2006, all DORS counselors will participate in a comprehensive system of personnel development that will include topics such as assessment, job development, career counseling, employer networking, etc.
Responsible Unit(s): Leads:

3.1.4 By July 2006, DORS, DDA and MHA will communicate to providers the expectations that training programs include career exploration and job seeking skills, and encourage

exposure of job seekers with disabilities to the services of local One Stops Career Centers.
Responsible Unit(s): Lead: DORS, DDA, MHA

3.1.5 By July 2006, training will be conducted for all One Stop staff and partners on how to better serve customers with disabilities.
Responsible Unit(s): Leads: DLLR

3.1.6 By January 2006, DORS, DDA and MHA will submit recommendations to MDOD to improve the availability /quality of and training for job coaches.
Responsible Unit(s): Leads: DORS, DDA, MHA

Key Strategy 3.2
By November 2006, increase access to all One Stop Career Centers through technology and programmatic changes.

Action Steps:

3.2.1 By December 2005, have access surveys done of all One Stops and action plans based on recommendations in place.
Responsible Unit(s): DLLR

3.2.2. By July 2006, have action plans based on access surveys implemented.
Responsible Unit(s): DLLR

3.2.3 By November 2006, each WIB region that obtained new Assistive technology will have a minimum of three staff trained on assistive technology.
Responsible Unit(s): DLLR

Key Strategy 3.3
By July 2006, assess the effectiveness of the Office on Blindness and Vision Services to determine the type and quality of vocational rehabilitation services provided to individuals who are blind or visually impaired.

Action Steps:

3.3.1 Through July 2006, monitor performance levels required by federal standards and indicators for separate agencies for the blind as well as additional key measures identified by consumers.
Responsible Unit(s): MDOD, DORS/OBVS

3.3.2 March – July 2006, through an interdisciplinary team comprised of representatives from MDOD, DORS, consumer advocacy organizations, a representative from the State Rehabilitation Council (SRC), and other stakeholders, conduct file reviews to identify the types of services provided; the appropriateness and adequacy of those services (including duration of training); consumer demographics; the categories of employment achieved by consumers; and other factors the team identifies as relevant.
Responsible Unit(s): MDOD, DORS/OBVS, SRC

3.3.3 By June 2006, MDOD and DORS/OBVS will conduct a joint/third party consumer satisfaction survey in order to determine how consumers themselves benefited from the new program, and how their experiences improved from those served under the previous structure.
Responsible Unit(s): MDOD, DORS/OBVS, SRC

3.3.4 By June 2006, MDOD, the SRC, and DORS will issue a joint evaluation report which will assess both the technical competence of staff and their attitudes towards blindness/visual impairment.
Responsible Unit(s): MDOD, DORS/OBVS, SRC

3.3.5 By July 2006, issue a report detailing the assessment that gives direction to establishing appropriate consumer centered performance-measures and outcomes for vocational rehabilitation services for people who are blind or visually impaired through the newly created OBVS within the DORS.
Responsible Unit(s): MDOD, DORS/OBVS

HEALTH AND BEHAVIORAL HEALTH

Vision: Maryland envisions a high quality and coordinated healthcare system for all its citizens, with and without disabilities, which offers easy and timely access to medical care and a variety of consumer choices within the full range of primary, specialty, acute and long-term health care services including behavioral health.

Goal: To assure that people with disabilities have access to a range of high quality and coordinated health care providers, including primary and specialty care physicians and other health care professionals who have specialized experience working with multiple need populations in order to address their preventive, acute and chronic health care needs.

Outcome 1: Eligible people with disabilities will have access to high quality and coordinated publicly funded behavioral health care.

Key Strategy 1.1
By September 1, 2006, develop a strategic plan to transform the delivery of publicly funded mental health services consistent with the President's New Freedom Commission on Mental Health and make recommendations to improve access, develop capacity, and provide resources for future system improvements.

Action Steps:

1.1.1 Create a Mental Health Transformation Working Group (MH-TWG) to oversee development of a comprehensive plan to transform mental health services in Maryland and to oversee special projects identified elsewhere in this plan including mental health self direction projects, Consumer Quality Team pilots, Co-occurring disorders pilots, acute care pilots and developing alternatives to seclusion and restraint in mental health facilities (see 1.1.2, 1.1.3 and 4.1.1 below.)
Co-Lead Agencies: DHMH, MDOD,GOC Participants; ADAA, DDA, DJS, DOC, other child and adult serving agencies as determined necessary

1.1.2 The DHMH Co-Occurring Disorders Leadership Team will continue its efforts to improve and integrate services for people with co-occurring psychiatric and substance abuse disorders through a combination of interagency collaboration, pilot projects, and policy reformulation, and report results and make recommendations on needed actions through the MH-TWG planning process.
Responsible Unit(s): DHMH (MHA, ADAA); MH-TWG

1.1.3 Convene a workgroup to study the benefits for people who experience mental illness receiving acute care treatment in communities where they live rather than state psychiatric hospitals. Include all stakeholders including consumers, families, local hospitals, emergency room doctors, hospital association, judiciary, state agencies and recommend changes to state policy through the MH –TWG planning process that shift emphasis to forensic and long term populations for state hospital utilization.
Responsible Unit(s): MHA; Participants, stakeholders identified above; MH-TWG

Outcome 2: People with disabilities will have the information and supports necessary to a) engage in work without loss of health care benefits and b) independently navigate the health care system.

Key Strategy 2.1
Implement the "Employed Persons with Disabilities Program" a first step towards creation of a full Medicaid Buy-In program for people with disabilities who, as a result of work, exceed the income limits for current Medicaid program eligibility.

Action Steps:

2.1.1 By January 2006, have draft regulations published.
Responsible Unit(s): Lead: Office of Health Services (Medicaid); Participants: DDA, MHA, DORS, MDOD

2.1.2 By March 2006, have the regulations finalized.
Responsible Unit(s): Lead: Office of Health Services (Medicaid); Participants: DDA, MHA, DORS, MDOD

2.1.3 Beginning in mid March, publicize the availability of the Buy-In and begin enrollment up to 350 individuals.
Responsible Unit(s): Lead: Office of Health Services (Medicaid); Participants: DDA, MHA, DORS, MDOD

2.1.4 By April 2006, have eligibility system in place and ready to process applications.
Responsible Unit(s): Lead: Office of Health Services (Medicaid); Participants: DDA, MHA, DORS, MDOD

2.1.5 Based on current funding projects, expand program to 450 individuals in 2007.
Responsible Unit(s): Lead: Office of Health Services (Medicaid); Participants: DDA, MHA, DORS, MDOD

Key Strategy 2.2
Implement a State Plan Medicaid Buy-In by the end of 2006 and position Maryland to maximize its ability to leverage federal CMS dollars for systems change activities related to employment.

Action Steps:

2.2.1 By December 1, 2005, Office of Health Services (Medicaid) will provide MDOD with the eligibility criteria specific to Maryland for the 2007 Comprehensive Medicaid Infrastructure grant competition and the action steps necessary to ensure eligibility including potential costs of items that may require additional funding.
Responsible Unit(s): Office of Health Services (Medicaid)

2.2.2 By December 1, 2006, pending eligibility determination, submit grant proposal to CMS for 2007 Comprehensive MIG funding.
Responsible Unit(s): Office of Health Services (Medicaid), MDOD

Outcome 3: People with disabilities will experience freedom from abuse and neglect and decreased utilization of involuntary or coercive seclusion, restraint, and unnecessary or excessive sedation.

Key Strategy 3.1
Establish a program of state of the art alternatives to the use of seclusion and restraint, including chemical restraint, in programs and settings supporting people with disabilities.

Action Step:

3.1.1 MHA will implement a program of alternatives to seclusion and restraint in all state operated psychiatric facilities during FY06 and report results of implementation and data on the incidence of seclusion and restraint to MDOD at the end of the fiscal year.
Responsible Unit(s): Lead Agency MHA

Outcome 4: People with disabilities will have increased access to and express increased satisfaction with their publicly funded health care services.

Key Strategy 4.1
Develop infrastructure and capacity at MDOD to assess the degree of access to and the extent of personal satisfaction with publicly funded health care services provided to people with disabilities in Maryland.

Action Step:

4.1.1 By July 1, 2006, MDOD and DHMH will review a comprehensive annual health care access and satisfaction report, developed using existing data and other pertinent qualitative measures, to describe the access to and personal satisfaction with health care services, including behavioral health, delivered to people with disabilities. This report should include the following:

- A definition of the population(s) of persons with disabilities included in the report within each specific health care program area. To the extent possible, the report should disaggregate people with disabilities into recognizable sub-groups (e.g. people with developmental, physical, and psychiatric disabilities, and other diagnostic categories if needed) for the data reporting purposes listed below.
- Data presentations drawn from utilization data to describe the degree of access of people with disabilities to a variety of health services by specific service types and specialties as compared to other non-disabled recipients of health care.
- Data presentations drawn from satisfaction instrumentation, related outcome measures, and/or qualitative methodology that describe the satisfaction with health care services and/or quality of life experienced by people with disabilities as compared to other non-disabled recipients of health care.
- A detailed interpretation of the results that clarify, further explain, show limitations, or raise new questions concerning the information presented.
- Recommendations for next steps in improved quality measurement, focus studies, or other strategies related to improved access and satisfaction.

Responsible Unit(s): Lead: DHMH, Office of Health Services (Medicaid) Participant-- MDOD

TECHNOLOGY AND COMMUNITIES

Vision: Maryland citizens with disabilities will enjoy services and jobs that are universally accessible.

Goal: To provide (a) state agency services and employment accessible to people with disabilities through the use of assistive technology and accessible information technology, and (b) statewide systems to make assistive technology purchases more available and affordable for individuals with disabilities.

Outcome 1: People with disabilities will have independent and equal access to services and funded through state agencies.

Key Strategy 1.1
By August 31, 2006, provide evaluation and technical assistance to the Maryland Department of Budget and Management to ensure that their website is compliant with COMAR 17.06 ("Information Technology Non-Visual Access Policy").

Action Steps:

1.1.1 Evaluate the DBM site to determine current degree of compliance with the NVA and identify any accessibility problems and/or areas of non- compliance.
Responsible Unit(s): MD TAP, MDOD, DBM

1.1.2 List Measures needed to remediate the problems.
Responsible Unit(s): MD TAP, MDOD, DBM

1.1.3 Consult with DBM web developer(s) to resolve the problems.
Responsible Unit(s): MD TAP, MDOD, DBM

1.1.4 Conduct a final review of the site following remediation to verify that the DBM site complies with the NVA.
Responsible Unit(s): MD TAP, MDOD, DBM

Key Strategy 1.2
By August 31, 2006, provide technical assistance, training and product evaluation to DBM to ensure that all information technology products purchased by that agency from that time forward are compliant with COMAR 17.06 ("Information Technology NonVisiual Access Policy").

Action Steps:

1.2.1 MDOD will provide four ½ day training sessions on how to procure IT products that comply with the NVA to procurement and IT staff selected by DBM.

1.2.2 MDOD will technically assist procurement officers and contract managers with the following for each of five jointly selected procurement bids by assisting with the design of the RFP and evaluating the degree of compliance with NVA for IT products included in vendor bids.
Responsible Unit(s): MD TAP, MDOD, DBM

Key Strategy 1.3
By June 30, 2006, consistent with the provisions of the Memorandum of Understanding between MDOD, DOA, DHMH, and DHR that commenced on January 1, 2005, create and coordinate a process for the Departments to achieve statewide systems change that accelerates consumers' access to eligibility determination and services from programs under the authority of the Departments

Action Steps:

1.3.1 By December 30, 2006, establish a working committee comprised of personnel from the departments who will meet to address relevant systems change information and strategies.
Responsible Unit(s): MDOD, MDOA

1.3.2 By February 28, 2006, identify all of the current efforts within the State to increase access to application for services and service information related to disabilities through web-based technologies.
Responsible Unit(s): Working Committee

1.3.3 By May 31, 2006, develop the standards and functional requirements necessary for State agencies to coordinate and integrate their efforts related to streamlining the delivery of services, service eligibility determination, and information referral through the use of information technology; and identify financial resources for statewide implementation.
Responsible Unit(s): Working Committee

1.3.4 By June 30, 2006, develop recommendations to be submitted to the Governor and the Maryland Department of Budget and Management for achieving statewide systems change that accelerates consumers' access to eligibility determination and services from programs under the authority of the Departments.
Responsible Unit(s): Working Committee

Outcome 2: Marylanders with disabilities who need to purchase assistive technology or accessible information technology for education, employment, community participation and greater independence will be able to do so more easily and affordably.

Key Strategy 2.1
By December 2006, inaugurate a statewide recycling program for wheelchairs and other durable medical equipment, in partnership with DHMH, to (a) reduce Medicaid expenditures by providing recycled rather than new equipment to Maryland Medicaid recipients; and (b) deliver surplus recycled equipment to Marylanders who are uninsured or underinsured and have low incomes, at no cost to recipients.

Action Steps:

2.1.1 By December 31, 2005, obtain approval for regulatory change needed to initiate the program.
Responsible Unit(s): Co-Lead(s): DHMH, MDTAP, MDOD

2.1.2 By January 31, 2006, secure approval from Centers for Medicare and Medicaid Services (CMS) for the request for proposals to solicit bids from contractors to operate the program.
Responsible Unit(s): Co-Lead(s): DHMH, MDTAP, MDOD

2.1.3 By March 31, 2006, issue request for proposals.
Responsible Unit(s): Co-Lead(s): DHMH, MDTAP, MDOD

2.1.4 By May 31, 2006, award contract.
Responsible Unit(s): Co-Lead(s): DHMH, MDTAP, MDOD

2.1.5 By August 31, 2006, oversee project initiation.
Responsible Unit(s): Co-Lead(s): DHMH, MDTAP, MDOD

Key Strategy 2.2
By July 1, 2006, expand the Maryland Assistive Technology Co-op (a non-profit purchasing cooperative that negotiates purchase discounts on a range of assistive technology products for educational organizations and individuals) by recruiting more educational and state agencies to become members and adding more items to the Co-op's product list.

Action Steps:

2.2.1 By June 30, 2006, the Co-op will recruit thirty-two (32) new educational organizations and state agencies to become members.
Responsible Unit(s): Co-Leads: MDTAP, Maryland AT Co-op

2.2.2 By June 30, 2006, the Co-op will offer discounts on forty (40) new products.
Responsible Unit(s): Co-Leads: MDTAP, Maryland AT Co-op

2.2.3 From July 1, 2006, onward, the Co-op's expansion will generate excess revenues to support other assistive technology projects in Maryland.
Responsible Unit(s): Co-Leads: MDTAP, Maryland AT Co-op

EDUCATION

Vision: Youth with disabilities will receive a free, high-quality public education in their neighborhood schools and emerge prepared and able to access employment or higher education.

Goal: To assure that all youth with disabilities have the necessary services and accommodations to succeed in their neighborhood schools and experience a smooth, successful transition to supported employment, job development, or institutions of higher education.

Outcome 1: Maryland students with disabilities will exit school with self advocacy, life and leadership skills.

Key Strategy 1.1
The State will offer leadership training opportunities for students with disabilities.

Action Steps:

1.1.1 By December 1, 2005, co-host an alumni training event of the Youth Leadership Forum.
Responsible Unit(s): Leads: Independence Now, MDOD

1.1.2 By April 1, 2006, recruit students with disabilities in their final two years of high school to participate in the MD YLF.
Responsible Unit(s): Leads: MSDE, DORS, MDOD

1.1.3 By July 1, 2006, recruit alumni of the MD YLF to serve as volunteer staff for the week long program.
Responsible Unit(s): Leads: MDOD

1.1.4 By September 1, 2006, host the 7th Annual Maryland Youth Leadership Forum.
Responsible Unit(s): Leads: Independence Now, MDOD, DORS, MSDE, SILC Partners: DDA, MDOT, DDC

Outcome 2: Students with disabilities will be able to access a full array of job training opportunities through community colleges and other educational and integrated community settings.

Key Strategy 2.1
By October 1, 2006, a Maryland Transition Services resource map will be developed and recommendations to improve the availability and quality of transition services will be included in the 2007 MDOD State Disabilities Plan.

Action Steps:

2.1.1 By February 1, 2006, project administrator and consultant for a Transition Service Resource Mapping project will be hired (pending approval of 2006 Medicaid Infrastructure Grant).
Responsible Unit(s): MDOD

2.1.2 By May 1, 2006, the Interagency Transition Council and key stakeholders to include parents and students will be engaged in a resource mapping process of transition services in Maryland.
Responsible Unit(s): Leads: Interagency Transition Council; Participants: MSDE, DORS, DDA, MHA, DLLR, MDOD

2.1.3 By September 1, 2006, a resource map, recommendations, key strategies and proposed action steps (using the MDOD state plan format) will be submitted to MDOD by the Interagency Transition Council.
Responsible Unit(s): Leads: Interagency Transition Council; Participants: MSDE, DORS, DDA, MHA, DLLR, MDOD

2.1.4 By July 1, 2006, revise and update the Interagency Transition Council Executive Order to meet current needs of the State as it relates to transition services and systems change in Maryland.
Responsible Unit(s): MDOD

Key Strategy 2.2

By October 2006, the State will have improved data collection and undertaken action to improve access and outcomes for students with disabilities in community colleges.

Action Steps:

2.2.1 By August 2005, Maryland Higher Education Commission (MHEC) and MDOD will convene a Task Force on Community College Students with Disabilities.
Responsible Unit(s): Leads: MHEC, MDOD Participants: DORS, DDA, MSDE, members of the House and Senate, parents, students and community college representatives.

2.2.2 By December 1, 2005, key priorities and recommendations will be submitted to the Governor and the Maryland General Assembly.
Responsible Unit(s): Leads: MHEC, MDOD Participants: DORS, DDA, MSDE, members of the House and Senate, parents, students and community college representatives.

2.2.3 By February 2006, recommendations will be disseminated to the agency and community colleges for follow up.
Responsible Unit(s): Leads: MDOD, MHEC Participants: To be determined based on recommendations.

Outcome 3: Maryland students in preschool through grade12 will have greater opportunities for inclusive classroom experiences.

Key Strategy 3.1
By April 2006, a workgroup of stakeholders will convene to review existing recommendations and ways in which greater opportunities for inclusive classroom settings might be available throughout Maryland.

Action Step:
3.1.1 By July 2006, identify strategies for inclusion in FY 2007 State Disabilities Plan.
Responsible Unit(s): Leads: MDOD

FAMILY SUPPORT SERVICES

Vision: Maryland is a state where caregivers, children with disabilities and their families will have equal access to an integrated support system that is self-directed, responsive, flexible and available.

Goal: To improve the capacity of communities to support caregivers, children with disabilities and their families with individualized community-based services, such as inclusive child care, that are driven by family defined needs.

Outcome 1: Children with disabilities and their families identify an improvement in daily functioning and increased satisfaction with services.

Key Strategy 1.1
Develop a comprehensive training infrastructure around inclusive childcare and after-school care.

Action Steps:

1.1.1 Review the existing credentialing program to incorporate training recommendations from the 2004 Taskforce on Inclusive Child and After-School Care. Implementation plan to be developed, on or before January 1, 2006, through the Maryland State Department of Education, Division of Early Childhood Development's Inclusive Child are Workgroup.
Responsible Unit(s): Lead: Maryland State Department of Education/ Division of Early Childhood Development-Office of Child Care; Participants: Members of DECD Inclusive Child Care Workgroup

1.1.2 Develop a model and implementation plan for a statewide tiered approach to training child care providers on supporting children with disabilities in child care settings. Implementation plan to be developed, on or before January 1, 2006, through the Maryland State Department of Education, Division of Early Childhood Development's Inclusive Child Care Workgroup.
Responsible Unit(s): Lead: Maryland State Department of Education/ Division of Early Childhood Development-Office of Child Care; Participants: Members of DECD Inclusive Child Care Workgroup

1.1.3 Develop an action plan and implementation schedule for phase two recommendations of the 2004 Taskforce on Inclusive Child and After-School Care. Implementation plan to be developed, on or before January 1, 2006, through the

Maryland State Department of Education, Division of Early Childhood Development's Inclusive Child Care Workgroup.
Responsible Unit(s): Lead: Maryland State Department of Education/ Division of Early Childhood Development-Office of Child Care; Participants: Members of DECD Inclusive Child Care Workgroup

Key Strategy 1.2
Develop a statewide infrastructure to improve the availability of inclusive child and after-school care, camps and summer programs.

Action Steps:

1.2.1 Develop and implement regulations supporting implementation and enforcement of the ADA as well as Section 504 in child and after-school care settings. Implementation plan to be developed, on or before January 1, 2006, through the Maryland State Department of Education, Division of Early Childhood Development's Inclusive Child Care Workgroup.
Responsible Unit(s): Lead: Maryland State Department of Education/ Division of Early Childhood Development-Office of Child Care; Participants: Members of DECD Inclusive Child Care Workgroup.

1.2.2 Develop a model and implementation plan for a statewide mediation program to be available to parents and providers of inclusive childcare, after-school care, camps, and summer programs. Implementation plan to be developed, on or before January 1, 2006, through the Maryland State Department of Education, Division of Early Childhood Development's Inclusive Child Care Workgroup.
Responsible Unit(s): Lead: Maryland State Department of Education/ Division of Early Childhood Development-Office of Child Care; Participants: Members of DECD Inclusive Child Care Workgroup.

1.2.3 Develop a comprehensive resource map relating to child and after-school care, camps and summer programs. Implementation plan to be developed, on or before January 1, 2006, through the Maryland State Department of Education, Division of Early Childhood Development's Inclusive Child Care Workgroup.
Responsible Unit(s): Lead: Maryland State Department of Education/ Division of Early Childhood Development-Office of Child Care; Participants: Members of DECD Inclusive Child Care Workgroup

Outcome 2: Children with disabilities and their families have a reduced number of contacts with the child welfare system.

Key Strategy 2.1
Improve services provided by public and private health insurance to children with disabilities, transitioning youth and their families.

Action Steps:

2.1.1 By August 1, 2006, complete a comprehensive evaluation of existing public and private health insurance programs available to children with disabilities, transitioning youth and their families.
Responsible Unit(s): MDOD

2.1.2 By August 1, 2006, identify specific policies and procedures regarding health insurance negatively impacting children with disabilities, transitioning youth and their families.
Responsible Unit(s): Lead: MDOD: Participants: Medicaid, Mental Hygiene Administration, Developmental Disabilities Administration, and the Governor's Office for Children.

2.1.3 By August 1, 2006, identify strategies for inclusion in the 2007 State Disabilities Plan.
Responsible Unit(s): Leads: MDOD

Outcome 3: Children with disabilities will have a reduced number of out-of-home placements and average length of stay in out-of-home care.

Key Strategy 3.1
Ensure that children with disabilities receive services and supports more effectively and through an integrated family-centered approach.

3.1.1 On or before January 1, 2006, the Children's Cabinet will develop training curricula on systems of care and wraparound individualized plans of care for use by management and direct care staff within Children's Cabinet agencies, and Local Management Boards. Time frames to be developed, on through the Governor's Office for Children.
Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children.

3.1.2 Develop system of care training curricula for families of children with disabilities to foster the growth of family support organizations throughout Maryland. Time frames to be developed, on or before January 1, 2006, through the Governor's Office for Children.

Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children

3.1.3 Determine the most effective means to maximize federal and state dollars to support systems of care and Maryland's Wraparound Model. Time frames to be developed, on or before January 1, 2006, through the Governor's Office for Children.
Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children

3.1.4 Assess the readiness of local jurisdictions (beyond Baltimore City and Montgomery County) to serve as future wraparound demonstration sites. Time frames to be developed, on or before January 1, 2006, through the Governor's Office for Children.
Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children.

3.1.5 Create and implement a system for assessing the quality of the wraparound sites (beginning with Baltimore City and Montgomery County) based on outcomes for the children and families and fidelity to Maryland's Wraparound Model. Time frames to be developed, on or before January 1, 2006, through the Governor's Office for Children.
Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children

Key Strategy 3.2
Develop a unified application for support services tied to a streamlined eligibility process to be utilized by member agencies of the Children's Cabinet serving children with disabilities.

Action Steps:

3.2.1 Undertake an analysis of the Maryland Results and Indicators and incorporate measurements specific to the health and well-being of children with disabilities and their families. Time frames to be developed, on or before January 1, 2006, through the Governor's Office for Children.
Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children

3.2.2 Assess the Local Access Plans prepared by the 24 Local Management Boards during FY2005 to determine ways in which current services may be more effectively streamlined and integrated in order to create a single point of access in each local jurisdiction for children with disabilities. Time

frames to be developed, on or before January 1, 2006, through the Governor's Office for Children.
Responsible Unit(s): Lead: the Children's Cabinet; Reporting Unit of Government: Governor's Office for Children

EMERGENCY PREPAREDNESS

Vision: Marylanders with disabilities will be prepared for any natural or man-made disaster or emergency, and be able to take care of their own basic needs for a minimum of 72 hours without formal emergency management assistance. Emergency personnel, provider agencies and employers will be as well prepared to deal with all major issues related to individuals with disabilities during any natural or man-made disaster or emergency, as they are to deal with issues faced by individuals without disabilities.

Goal: To develop and implement a statewide plan to prepare people with disabilities for any natural or man-made emergency or general disasters or emergency, and prepare emergency personnel, provider agencies and employers to provide equally excellent emergency services to Maryland residents with and without disabilities.

Outcome 1: People with disabilities will be prepared to survive an emergency or general disaster, and to meet all basic needs while sheltering in place for a minimum of 72 hours.

Key Strategy 1.1
By July 1, 2006, develop and implement up to four additional regional committees and training forums introducing viable approaches to preparing individuals with disabilities for an emergency or disaster.

Action Step:

1.1.1 By April 1, 2006, obtain adequate funding for personnel, education and training, curriculum development and materials, and public relations activities to support the formation and implementation of committees and training forums.
Responsible Unit(s): MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

Key Strategy 1.2
By December 1, 2006, establish a network of at least five hundred people, including individuals with disabilities and other special needs, and other individuals and organizations throughout Maryland that are interested in emergency preparedness inclusive of people with disabilities or special needs.

Action Steps:

1.2.1 By December 1, 2005, obtain adequate funding to support this strategy.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

1.2.2 By January 1, 2006, recruit an Advisory committee to include individuals with disabilities, migrants and individuals whose

primary language is not English, as well as members of organizations representing these groups to support the formation of a broad emergency preparedness network of communication.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

1.2.3 By July 1, 2006, design and test the developed system.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

1.2.4 By September 1, 2006, conduct an extensive public relations effort to recruit members to use and support the network.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

Key Strategy 1.3
By September 1, 2006, develop and implement a statewide conference to provide a greater depth of information and more individualized planning to specific groups or populations than the previous conferences.

Action Steps:

1.3.1 By February 1, 2006, conduct a survey of individuals with disabilities, first responders, and management and employees of community provider agencies to determine a portion of content for conference.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

1.3.2 By March 1, 2006, develop relationships with several private companies to fund the contents of emergency kits to be distributed at conference.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

1.3.3 By May 1, 2006, contract with community colleges in state (at no cost) to host a conference at various colleges on same day via video conferencing.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

1.3.4 By June 1, 2006, arrange video conferencing capabilities to allow all regions of state to participate in conference.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH

Key Strategy 1.4
By June 1, 2006, increase outreach efforts to non-English speaking persons and migrant workers.

Action Steps:

1.4.1 By December 1, 2006, recruit key community leaders and groups to participate in creating and sustaining new communication channels.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH, DHR, and DJS

1.4.2 By March 1, 2006, establish relationships with non-English speaking media sources (radio, TV) to broadcast emergency information in accessible and adaptable formats for a variety of cultural groups, including non-English speaking persons.
Responsible Unit(s): Lead: MDOD; Participants: Military (MEMA), GOSV, Department of Homeland Security, DHMH, DHR, and DJS

Outcome 2: People with disabilities will be able to shelter in place during a disaster or emergency, or be able to evacuate when necessary by appropriate transportation means to designated shelters.

Key Strategy 2.1
By December 1, 2006, in conjunction with community provider agencies, develop and implement a plan to ensure that essential services to the customers of community provider agencies continue during a disaster or emergency both when sheltering in place or in a shelter.

Action Steps:

2.1.1 By December 1, 2005, develop and conduct a one day statewide training for leaders and managers of organizations and facilities focusing on the requirements for providing appropriate emergency preparedness for clients in their service.
Responsible Unit(s): Lead: MDOD; Participants: DHMH (DDA, MHA), DOA, GOSV, Military (MEMA), Department of Homeland Security

2.1.2 By April 1, 2006, design and implement work sessions with teams from community provider organizations to assist the teams in completing their development or revision of their own organization's emergency plan, including their sheltering in place and evacuation plans.

Responsible Unit(s): Lead: MDOD; Participants: DHMH (DDA, MHA), DOA, GOSV, Military (MEMA), Department of Homeland Security

2.1.3 By July 1, 2006, develop and present tabletop exercises to 30 community provider agencies.
Responsible Unit(s): Lead: MDOD; Participants: DHMH (DDA, MHA), DOA, GOSV, Military (MEMA), Department of Homeland Security

Outcome 3: Employees with disabilities will be provided resources and training to enable them to appropriately and safely shelter in place or evacuate to a safe location.

Key Strategy 3.1
By February 1, 2006, meet with representatives from four state departments or agencies, and develop a consistent sheltering in place, evacuation and transportation plan and training program for employees and visitors who work in or visit these buildings.

Action Step:

3.1.1 By May 1, 2006, develop a system for monitoring the implementation of these standards as well as a system for communicating the plan to all employees**.**
Responsible Unit(s): Lead: MDOD; Participants: DGS, DBED, DHR

Section 4

This section describes how MDOD will work with units of state government to implement and evaluate performance in relation to the State Disabilities Plan.

- Implementation and Performance Evaluation
- Development of Unit Plans
- Unit Plan Progress Assessment
- Annual State Progress Analysis

IMPLEMENTATION AND PERFORMANCE EVALUATION

Performance measurement begins with visions, goals, outcomes and strategies for each of the nine service domains, as presented in Section Three. As outlined below, these elements will serve as the basis for developing unit plans in alignment with the State Disabilities Plan; evaluating unit performance against unit plans; and preparing the Annual State Progress Analysis.

Legislative Authority (§ 9-1115) The Interagency Disabilities Board is charged with:

- Facilitating the development of performance objectives that will result in a comprehensive, effective, efficient and integrated service delivery system for individuals with disabilities; and
- Developing the State Disabilities Plan.

Timeline

FY 2006 – FY 2007	
State Disabilities Plan	December 1, 2005
Unit Plan Progress Assessment	April 1, 2006
Unit Evaluations	July 1, 2006
Annual Progress Analysis	October 1, 2006

DEVELOPMENT OF UNIT PLANS

Legislative Authority (§ 9-1108)

- By July 1 of each year, each unit of state government shall develop a unit plan to implement the state disabilities plan as approved or amended by the Secretary under § 9-1117 of this subtitle.
- The unit plan shall contain an implementation schedule and measurable strategic performance objectives.
- The Secretary may request amendments to a unit plan if determined that the unit plan is not in accordance with the State Disabilities Plan.
- The Secretary may provide technical assistance to any unit of state government to meet the requirements of this section.
- The Secretary may waive the requirements of this section for any unit of state government.

Collaboration Efforts

MDOD works in collaboration with units of state government to develop individual and interagency action plans needed to carry out key strategies and to identify performance measures for the articulated outcomes. MDOD also serves as a resource and facilitator among various stakeholders and will provide technical assistance that units may need to fulfill their planning and evaluation requirements.

Implementation Schedules

In collaboration with units of state government, MDOD develops action plans to support priority strategies. When implementation of a strategy requires an inter-agency effort, MDOD works with relevant units of state government to develop an integrated action plan.

Measurable Strategic Performance Objectives

Collaborating with units of state government, MDOD will identify or develop indicators to measure results for the State Disabilities Plan's outcomes. To establish appropriate performance measures, MDOD and the Department of Budget and Management have jointly conducted a series of collaborative meetings with other units of government to discuss gathering data for performance measures with regard to employment and training services; community support services; and transportation services. Additional outcomes for other service domains will be developed once these initial measurements and processes are in place.

Participating units, by service domain include:

- *Community Integration* – Medicaid, DDA, MHA;
- *Transportation* – MDOT/MTA; and
- *Employment and Training* – MSDE/DORS, DLLR, DDA, and MHA.

Collaborating with units of state government, MDOD will establish timeframes for:

- Collecting available baseline data for identified measures;
- Ongoing collection of data; and
- Establishing objectives for subsequent years.

UNIT EVALUATIONS

Legislative Authority (§ 9-1108):

By July 1 of each year, each unit of state government shall provide the Department with an evaluation of the unit's performance in accordance with the unit's plan.

The required unit evaluation shall: (1) assess the unit's performance against the strategic performance objectives established under the unit plan, and (2) identify and measure consumer satisfaction; gaps in services; numbers of individuals waiting for services; and progress made on achieving performance objectives.

Implementation Evaluation

MDOD will work with units of state government to assess progress in implementing priority strategies in the State Disabilities Plan. Status reports will assess the status of each major action step – completed, in progress or not started. Status reports also will include related factors such as: issues, barriers or problems encountered in implementing strategies; recommendations to overcome issues, barriers, or problems; and resources required, etc.

Outcome Evaluation

- Units of state government will report baseline data available for selected performance measures pertaining to outcomes in the State Disabilities Plan.
- Measurable Strategic Performance Objectives for subsequent years will be set and presented MDOD's annual Managing for Results (MFR) submissions.
- Performance against these objectives will be measured by ongoing data collected and included in annual MFR submissions.

ANNUAL STATE PROGRESS ANALYSIS

Legislative Authority (§ 9-1117)

The Secretary shall submit an annual analysis of the State's progress in implementing the State Disabilities Plan and related performance objectives to the Governor and, in accordance with § 2-1246 of this article, to the Maryland General Assembly on or before October 1 of each year.

State Implementation Evaluation

- MDOD will update and collate information from the July strategic progress assessments.
- MDOD will use this information to prepare a comprehensive analysis of progress in implementing the State Disabilities Plan.
- MDOD will report intervention taken to address issues identified in the July progress assessments and will modify the State Plan to reflect planned future interventions.

Outcome Evaluation

- MDOD will report available baseline performance data, measurable strategic performance objectives for State Plan outcomes, and performance against objectives in MDOD's annual MFR submission.
- The MDOD MFR submission for FY 2006 listed selected performance measures for Employment and Training Services; Community Support Services; and Transportation Services.

Section 5

Appendices

- State Plan Score Sheet
- Maryland Department of Disabilities Principal Units of State Government Partnering in Implementing State Disabilities Plan
- Proposed New Regulations by State Agencies
- Checklist for Statewide Community Integration Plan
- Maryland Commission on Disabilities

APPENDIX 1

STATE PLAN SCORE SHEET

Mission and Consumer Perspective

Critical Success Factors:

Service Domains

Does the recommendation impact one or more of the following service domains?

- Personal attendant care and other long-term services (Community Integration)
- Accessible, integrated and affordable and housing options (Housing)
- Reliable transportation services (Transportation)
- Employment and training services (Training & Employment)
- Health and mental health services (Health)
- Accessible and universally-designed technology and communities (Technology & Communities)
- Educational support services for children, youth and their families and adults (Educational Support)
- Family Support Services, including respite care (Family Support Services)
- Emergency Preparedness

Disability

Does the recommendation affect one or more of the following disability categories?

- Cognitive Disability
- Neurological or Neuromuscular Disability
- Psychiatric Disability
- Blindness
- Deaf or Hard of Hearing
- Physical Disability
- Combination of Disabilities

Principles of Empowerment (Focus Area 3)

Does the recommendation incorporate the following principles?

- Expanded choice and options for consumers
- Consumer control
- Increased community capacity
- High expectations
- Involvement of consumers in policy-making implementation
- Involvement of consumers in program evaluation
- Information flow

Community Integration (Focus Area 5)

Does the recommendation incorporate one or more of the following measures to help gain full compliance with the Olmstead decision?

- Designing innovative means by which individuals with disabilities can access services in their communities rather than in institutions or nursing homes
- Identifying those in need of community-based services
- Aligning the funding of services with community-based alternatives
- Expanding the quality and quantity of community providers
- Educating consumers on their community options
- Reviewing policies, regulations and practices to ensure they support community options
- Collaborating with all stakeholders to create appropriate and integrated alternatives for persons with disabilities

Organizational Performance Perspective

Critical Success Factors:

Capacity Development (Focus Area 4)

Will the recommendation result in one or more of the following outcomes?

- Identifying gaps in service delivery, numbers of individuals needing services, projected costs and other quantifiable factors
- Creating realistic solutions that consider interagency resources and needs
- Improving capacity to meet needs in specific service domains that warrant expansion and/or retooling

Financial Resources

Will the recommendation result in one or more of the following outcomes, and what fiscal impact will the recommendation have?

- Leveraging of additional resources including federal and/or private funds
- Reduced administrative expenditures
- Reduced operational expenditures
- Savings derived from improved outcomes
- Relevant methods of tracking expenditures

Program Evaluation and Accountability (Focus Area 1)

Does the recommendation address the following accountability standards?

- Current baseline data
- Measurable and consumer-based outcomes
- Performance measures and indicators
- Data tracking system and identification of relevant data sets
- Strategies to ascertain consumer satisfaction

Processes and Structures

Critical Success Factors:

Program and Work Flow Improvements (Focus Area 2)

Will the recommendation facilitate one or more of the following outcomes?

- Program consolidation
- Process consolidation
- Enhanced coordination
- Consolidation of personnel functions
- Elimination of a service gap
- Increased connection to other services
- Reduction in paperwork (when appropriate)
- Reduction in process burden (when appropriate)

Vehicles for Change

What structures need to change in order for the recommendation to be implemented?

- Statute
- Regulations
- Policies
- Practices
- Organizational Culture

APPENDIX 2

MARYLAND DEPARTMENT OF DISABILITIES PRINCIPAL UNITS OF STATE GOVERNMENT PARTNERING IN IMPLEMENTING STATE DISABILITIES PLAN

MDOD's enabling statute defines a unit of state government as: any department, agency, office, commission, council or other unit of the State within the Executive Branch of state government (§ 9-1101(g)). The following list delineates principal departments and administrations that MDOD will collaborate with in implementing the State Disabilities Plan, and that may be required to submit an evaluation of their performance by January 1, 2006. (Section 4 contains a more detailed timeline for unit plan progress assessment and submission dates).

APPENDIX 3

PROPOSED NEW REGULATIONS BY STATE AGENCIES

The process by which a State of Maryland agency may propose new regulations, or amend existing ones, has generally required that an impact statement be produced if the proposed action has an effect on the welfare of the public. An impact statement is an estimate of the anticipated beneficial or adverse effects to the health, safety, welfare, economic costs and the environment of the State and its citizens.

Now, under § 9-1104 (c)(2), Annotated Code of Maryland, July 1, 2004, creating the Maryland Department of Disabilities, agencies are required to produce an assessment and impact statement if the proposed regulations affect individuals with disabilities. The Division of State Documents will publish the impact statement with each proposal in the Maryland Register. As part of the form package, the Division of Documents will present the State agencies with options which answer the following questions:

Impact on Individuals with Disabilities

- The proposed action has no impact on individuals with disabilities.
- The proposed action has an impact on individuals with disabilities.

Whichever option is checked will be printed in the Maryland Register.

APPENDIX 4

MARYLAND DEPARTMENT OF DISABILITIES
2006 STATE DISABILITIES PLAN
COMMUNITY INTEGRATION

CHECKLIST FOR STATEWIDE COMMUNITY INTEGRATION PLAN

Checklist Element	Assessment	Transition	Diversion	Long-term Community Supports
Administrative				
Stakeholder participation in administrative plan development and implementation				
State statutes and federal requirements				
Programs or services				
Target population (define)				
Criteria for prioritizing based on risk of institutionalization				
Methods to determine preferences and needs				
Attach policy requiring individual community support plan.				
Attach community support plan (CSP) document / form.				
Timelines				
Timeline compliance methods and rates				
Methods to facilitate community integration*				
Staff development on community integration				
Methods to share HCBS information				
Quality improvement plan, by program				

*Such as outreach and education programs, peer-to-peer mentoring, service coordination/case management/options counseling, and others best practices

Checklist Element	Assessment	Transition	Diversion	Long-term Community Supports
Quantitative				
Target population size				
Plan: Schedules: monthly and annual numerical targets and timeframes				
# Assessments				
# Preferring community placement				
# With CSP				
# With CSP actively being pursued				
# Receiving services as specified in CSP				
# Receiving HCBS, by program				
# On HCBS waiting lists/registries, by program				
# With CSP, remaining/ entering institutions				
# With CSP, transitioned /diverted				
Actual: Quarterly and annual reports, actuals compared to scheduled targets (above)				
Other outcome measures				
Staff resources and associated funding designated to each program/service				

Checklist Element	Assessment	Transition	Diversion	Long-term Supports
Capacity Development				
Stakeholder participation in capacity development plan and implementation				
Needs Assessment: Identify types and amounts of needed community integration services, based on: CSP data:				
Quantify available community integration services to meet CSP needs				
Gap Analysis**:** Compute service capacity and infrastructure gaps				
Recommendations to redesign services				
Recommendations to redirect resources				
Technical, cost, and schedule feasibility to meet identified gaps				

APPENDIX 5

MARYLAND COMMISSION ON DISABILITIES

Membership

Basehart, Sarah

Benson, Joanne

Brathwaite, Janice

Britt, Gwendolyn

Bynum, Edward J.

Capone, Kenneth S.

George, Jamey E.

Holland, Susan W.

Krout, Robin A.

Mitchell, Van

Nicole, Marc

Otto, Dale

Riccobono, Melissa

Rizzo, Juliette

Rock, Mary Alisa

Schulz, Mark J.

Sweeney, Robert J.

Ward, C. David

Weglein, Elizabeth

Wireman, Kenneth R.